

# Advanced Control Specialty Formulary™

The **CVS/caremark® Advanced Control Specialty Formulary™** is a guide within select therapeutic categories for clients, plan members and health care providers. **Generics should be considered the first line of prescribing.** If there is no generic available, there may be more than one brand-name medicine to treat a condition. These preferred brand-name medicines are listed to help identify products that are clinically appropriate and cost-effective. Generics listed in therapeutic categories are for representational purposes only. This is not an all-inclusive list. This list represents brand products in CAPS, branded generics in upper- and lowercase *Italics*, and generic products in lowercase *italics*.

## PLAN MEMBER

Your benefit plan provides you with a prescription benefit program administered by CVS/caremark. Ask your doctor to consider prescribing, when medically appropriate, a preferred medicine from this list. Take this list along when you or a covered family member sees a doctor.

### Please note:

- Your specific prescription benefit plan design may not cover certain products or categories, regardless of their appearance in this document. Products recently approved by the U.S. Food and Drug Administration (FDA) may not be covered upon release to the market.
- You may be responsible for the full cost of non-formulary products that are removed from coverage.
- For specific information regarding your prescription benefit coverage and copay<sup>1</sup> information, please visit [www.caremark.com](http://www.caremark.com) or contact a CVS/caremark Customer Care representative.
- CVS/caremark may contact your doctor after receiving your prescription to request consideration of a drug list product or generic equivalent. This may result in your doctor prescribing, when medically appropriate, a different brand-name product or generic equivalent in place of your original prescription.
- In most instances, a brand-name drug for which a generic product becomes available will be designated as a non-preferred option upon release of the generic product to the market.

## HEALTH CARE PROVIDER

Your patient is covered under a prescription benefit plan administered by CVS/caremark. As a way to help manage health care costs, authorize generic substitution whenever possible. If you believe a brand-name product is necessary, consider prescribing a brand name on this list.

### Please note:

- Generics should be considered the first line of prescribing.
- This drug list represents a summary of prescription coverage. It is not all-inclusive and does not guarantee coverage. The member's specific prescription benefit plan design may not cover certain products or categories, regardless of their appearance in this document. Products recently approved by the FDA may not be covered upon release to the market.
- The member's prescription benefit plan may have a different copay for specific products on the list.
- Unless specifically indicated, drug list products will include all dosage forms.
- Log in to [www.caremark.com](http://www.caremark.com) to check coverage and copay information for a specific medicine.

### ANALGESICS

#### VISCOSUPPLEMENTS

GEL-ONE  
HYALGAN  
SUPARTZ

### ANTI-INFECTIVES

#### ANTIRETROVIRAL AGENTS

§ ANTIRETROVIRAL COMBINATIONS  
*lamivudine-zidovudine*  
ATRIPLA  
COMPLERA  
EPZICOM  
EVOTAZ  
PREZCOBIX  
STRIBILD  
TRIUMEQ  
TRUVADA

#### FUSION INHIBITORS

FUZEON

#### INTEGRASE INHIBITORS

ISENTRESS  
TIVICAY

#### § NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS

*nevirapine*  
EDURANT  
INTELENCE  
RESCRIPTOR  
SUSTIVA  
VIRAMUNE XR

#### § NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS

*abacavir*  
*didanosine*

*lamivudine*  
*stavudine*  
*zidovudine*  
EMTRIVA

#### NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS

VIREAD

#### PROTEASE INHIBITORS

KALETRA  
NORVIR  
PREZISTA  
REYATAZ

#### ANTIVIRALS

§ HEPATITIS B AGENTS  
*entecavir tablet*  
*lamivudine*  
BARACLUDE SOLUTION

#### § HEPATITIS C AGENTS

*ribavirin*  
HARVONI  
SOVALDI

### ANTINEOPLASTIC AGENTS

#### § ALKYLATING AGENTS

*temozolomide*

#### § ANTIMETABOLITES

*capecitabine*

#### HORMONAL ANTINEOPLASTIC AGENTS

§ ANTIANDROGENS  
ZYTIGA

§ LUTEINIZING HORMONE-RELEASING HORMONE (LHRH) AGONISTS

*leuprolide acetate*

LUPRON DEPOT  
TRELSTAR  
ZOLADEX

#### IMMUNOMODULATORS

REVLIMID  
THALOMID

#### KINASE INHIBITORS

AFINITOR  
BOSULIF  
GLEEVEC  
NEXAVAR  
SPRYCEL  
SUTENT  
TARCEVA  
TYKERB  
VOTRIENT

§ MISCELLANEOUS  
TARGRETIN CAPSULE  
ZOLINZA

**CARDIOVASCULAR**

PULMONARY ARTERIAL HYPERTENSION  
 ENDOTHELIN RECEPTOR ANTAGONISTS  
 LETAIRIS  
 TRACLEER

§ PHOSPHODIESTERASE INHIBITORS  
*sildenafil*

PROSTAGLANDIN VASODILATORS  
 TYVASO  
 VENTAVIS

**CENTRAL NERVOUS SYSTEM**

MULTIPLE SCLEROSIS AGENTS  
 AUBAGIO  
 BETASERON  
 COPAXONE  
 GILENYA  
 REBIF  
 TECFIDERA

**ENDOCRINE AND METABOLIC**

CALCIUM REGULATORS  
 PARATHYROID HORMONES  
 FORTEO

FERTILITY REGULATORS  
 GNRH / LHRH ANTAGONISTS  
 CETROTIDE

§ OVULATION STIMULANTS, GONADOTROPINS  
*chorionic gonadotropin - Novarel*  
 FOLLISTIM AQ  
 OVIDREL

HUMAN GROWTH HORMONES  
 HUMATROPE

**HEMATOLOGIC**

HEMATOPOIETIC GROWTH FACTORS  
 ARANESP

NEULASTA  
**IMMUNOLOGIC AGENTS**

ALLERGENIC EXTRACTS  
 ORALAIR

BIOLOGIC DISEASE-MODIFYING AGENTS  
 ENBREL  
 HUMIRA

§ DISEASE-MODIFYING ANTIRHEUMATIC DRUGS (DMARDs)  
 RASUVO

IMMUNOMODULATORS  
 INTERFERONS  
 PEGINTRON

IMMUNOSUPPRESSANTS  
 § ANTIMETABOLITES  
*mycophenolate mofetil*  
 MYFORTIC

§ CALCINEURIN INHIBITORS  
*cyclosporine*  
*cyclosporine, modified*  
*tacrolimus*

§ RAPAMYCIN DERIVATIVES  
*sirolimus tablet*  
 RAPAMUNE SOLUTION

**TOPICAL**

MOUTH / THROAT / DENTAL AGENTS  
 PROTECTANTS  
 MUGARD

**QUICK REFERENCE DRUG LIST**

**A**  
*abacavir*  
 AFINITOR  
 ARANESP  
 ATRIPLA  
 AUBAGIO

**B**  
 BARACLUDE SOLUTION  
 BETASERON  
 BOSULIF

**C**  
*capecitabine*  
 CETROTIDE  
*chorionic gonadotropin - Novarel*  
 COMPLERA  
 COPAXONE  
*cyclosporine*  
*cyclosporine, modified*

**D**  
*didanosine*

**E**  
 EDURANT  
 EMTRIVA  
 ENBREL  
*entecavir tablet*  
 EPZICOM  
 EVOTAZ

**F**  
 FOLLISTIM AQ  
 FORTEO  
 FUZEON

**G**  
 GEL-ONE  
 GILENYA  
 GLEEVEC

**H**  
 HARVONI  
 HUMATROPE  
 HUMIRA  
 HYALGAN

**I**  
 INTELENCE

ISENTRESS

**K**  
 KALETRA

**L**  
*lamivudine*  
*lamivudine-zidovudine*  
 LETAIRIS  
*leuprolide acetate*  
 LUPRON DEPOT

**M**  
 MUGARD  
*mycophenolate mofetil*  
 MYFORTIC

**N**  
 NEULASTA  
*nevirapine*  
 NEXAVAR  
 NORVIR

**O**  
 ORALAIR  
 OVIDREL

**P**  
 PEGINTRON  
 PREZCOBIX  
 PREZISTA

**R**  
 RAPAMUNE SOLUTION  
 RASUVO  
 REBIF  
 RESCRIPTOR  
 REVLIMID  
 REYATAZ  
*ribavirin*

**S**  
*sildenafil*  
*sirolimus tablet*  
 SOVALDI  
 SPRYCEL  
*stavudine*  
 STRIBILD  
 SUPARTZ  
 SUSTIVA  
 SUTENT

**T**  
*tacrolimus*  
 TARCEVA  
 TARGRETIN CAPSULE  
 TECFIDERA  
*temozolomide*  
 THALOMID  
 TIVICAY  
 TRACLEER  
 TRELSTAR  
 TRIUMEQ  
 TRUVADA  
 TYKERB  
 TYVASO

**V**  
 VENTAVIS  
 VIRAMUNE XR  
 VIREAD  
 VOTRIENT

**Z**  
*zidovudine*  
 ZOLADEX  
 ZOLINZA  
 ZYTIGA

**PREFERRED OPTIONS FOR EXCLUDED SPECIALTY MEDICATIONS <sup>2</sup>**

DRUG NAME(S)	PREFERRED OPTION(S)*	DRUG NAME(S)	PREFERRED OPTION(S)*
ACTEMRA	ENBREL, HUMIRA	GENOTROPIN	HUMATROPE
ADCIRCA	<i>sildenafil</i>	GONAL-F	FOLLISTIM AQ
AVONEX	AUBAGIO, BETASERON, COPAXONE, GILENYA, REBIF, TECFIDERA	<i>Hecoria</i>	<i>tacrolimus</i>
BRAVELLE	FOLLISTIM AQ	KINERET	ENBREL, HUMIRA
CIMZIA	ENBREL, HUMIRA	MONOVISC	GEL-ONE, HYALGAN, SUPARTZ
EUFLEXXA	GEL-ONE, HYALGAN, SUPARTZ	NORDITROPIN	HUMATROPE
EXTAVIA	AUBAGIO, BETASERON, COPAXONE, GILENYA, REBIF, TECFIDERA	NUTROPIN AQ	HUMATROPE
		OMNITROPE	HUMATROPE
		OPSUMIT	LETAIRIS, TRACLEER

Your specific prescription benefit plan design may not cover certain products or categories, regardless of their appearance in this document. For specific information, visit [www.caremark.com](http://www.caremark.com) or contact a CVS/caremark Customer Care representative.



DRUG NAME(S)	PREFERRED OPTION(S)*	DRUG NAME(S)	PREFERRED OPTION(S)*
ORENCIA	ENBREL, HUMIRA	REVATIO	<i>sildenafil</i>
ORTHOVISC	GEL-ONE, HYALGAN, SUPARTZ	SAIZEN	HUMATROPE
OTEZLA	ENBREL, HUMIRA	SIMPONI	ENBREL, HUMIRA
PEGASYS	PEGINTRON	STELARA	ENBREL, HUMIRA
PLEGRIDY	AUBAGIO, BETASERON, COPAXONE, GILENYA, REBIF, TECFIDERA	SYNVISC, SYNVISC-ONE	GEL-ONE, HYALGAN, SUPARTZ
PROCRIIT	ARANESP	TASIGNA	BOSULIF, GLEEVEC, SPRYCEL
PROGRAF	<i>tacrolimus</i>	TEV-TROPIN	HUMATROPE
PROLIA	<i>alendronate, calcitonin-salmon, ibandronate</i> , ACTONEL, ATELVIA, FORTEO	VIEKIRA PAK	HARVONI
REMICADE	ENBREL, HUMIRA	XELJANZ	ENBREL, HUMIRA
REPRONEX	CETROTIDE, FOLLISTIM AQ	XTANDI	ZYTIGA

You may be responsible for the full cost of certain non-formulary products that are removed from coverage. Please check with your plan sponsor for more information.

**FOR YOUR INFORMATION: Generics should be considered the first line of prescribing.** This drug list represents a summary of prescription coverage. It is not all-inclusive and does not guarantee coverage. New-to-market products and new variations of products already in the marketplace will not be added to the formulary until the product has been evaluated, determined to be clinically appropriate and cost-effective, and approved by the CVS/caremark Pharmacy and Therapeutics Committee (or other appropriate reviewing body). In most instances, a brand-name drug for which a generic product becomes available will be designated as a non-preferred option upon release of the generic product to the market. Specific prescription benefit plan design may not cover certain products or categories, regardless of their appearance in this document. The member's prescription benefit plan may have a different copay for specific products on the list. Unless specifically indicated, drug list products will include all dosage forms. This list represents brand products in CAPS, branded generics in upper- and lowercase *italics*, and generic products in lowercase *italics*. Generics listed in therapeutic categories are for representational purposes only. Listed products may be available generically in certain strengths or dosage forms. Dosage forms on this list will be consistent with the category and use where listed. Log in to [www.caremark.com](http://www.caremark.com) to check coverage and copay information for a specific medicine.

\* The preferred options in this list are a broad representation within therapeutic categories of available treatment options and do not necessarily represent clinical equivalency.

§ Generics are available in this class and should be considered the first line of prescribing.

<sup>1</sup> Copayment, copay or coinsurance means the amount a member is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

<sup>2</sup> An exception process is in place for specific clinical or regulatory circumstances that may require coverage of an excluded medication.

**Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.**

CVS/caremark may receive rebates, discounts and service fees from pharmaceutical manufacturers for certain listed products. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS/caremark. Listed products are for informational purposes only and are not intended to replace the clinical judgment of the prescriber. The document is subject to state-specific regulations and rules, including, but not limited to, those regarding generic substitution, controlled substance schedules, preference for brands and mandatory generics whenever applicable.

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[www.caremark.com](http://www.caremark.com)

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